United States Senate

Committee on Finance

Washington, D.C. 20510

For Immediate Release
Tuesday, March 9, 2010

Senators seek information about safety, quality in long-term care hospitals

WASHINGTON – Senators Chuck Grassley and Max Baucus are asking for information about patient safety and quality of care in long-term care hospitals, in response to allegations reported last month by *The New York Times*.

Baucus is Chairman and Grassley is Ranking Member of the Senate Committee on Finance, which is responsible for Medicare legislation and oversight.

"Medicare beneficiaries and taxpayers deserve more information when questions are raised about safety and quality. If allegations are proven true, then there ought to be accountability," Grassley said.

"These reports of practices at Select Medical hospitals are alarming. Medicare patients deserve the safest and highest quality care in all facilities. Patient care should be determined by what's best for the patient, not what's best for a hospital's bottom line," said Baucus.

The senators sent letters to the Government Accountability Office, which is the independent investigative arm of Congress, and Select Medical Corporation. The text of those letters from Baucus and Grassley is below, along with the February 10 news story that prompted the inquiry.

March 8, 2010

The Honorable Gene L. Dodaro
Acting Comptroller General of the United States
Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dodaro:

We are writing regarding the February 10, 2010, New York Times article entitled "Long-Term Care Hospitals Face Little Scrutiny" in which Select Medical Corporation (Select Medical) is discussed. A copy of the article is enclosed. This article describes a number of disturbing incidents reported to have occurred in Select Medical long-term care hospitals (LTCHs) that

allegedly resulted in patient deaths and contains a host of other allegations about Select Medical including, but not limited to:

- Unusually high rates of violations of Medicare requirements;
- Poor health care quality;
- Inadequate staffing in terms of the type and number of practitioners;
- High staff turnover rates; and
- Inadequate patient monitoring.

We find these allegations to be of great concern, especially if they are systemic in facilities operated by Select Medical or in the LTCH industry as a whole, as the article suggests. If these allegations are true, then Medicare beneficiaries who receive services at LTCHs are being exposed to an unreasonable risk of harm.

We therefore request that the General Accountability Office (GAO) review various issues related to oversight of LTCHs. Specifically, we would appreciate GAO's examination of the level and type of oversight that is conducted related to patient care provided at LTCHs relative to other facilities and long-term care settings, including hospitals and skilled nursing facilities. As part of this, we would request information on what types of quality and patient safety information the Centers for Medicare & Medicaid Services (CMS) collect regarding LTCHs. Finally, we request an examination of the coordination between CMS, state survey and certification agencies, and private accrediting entities to ensure that LTCHs are providing quality care to Medicare beneficiaries.

Thank you in advance for your attention to this important matter.

Sincerely,

Max Baucus
United States Senator
Chairman of the Committee on Finance

Chuck Grassley
United States Senator
Ranking Member of the Committee on Finance

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March 8, 2010

Robert A. Ortenzio
Chief Executive Officer
Select Medical Corporation
4718 Old Gettysburg Road

P.O. Box 2034
Mechanicsburg, PA 17055

Dear Mr. Ortenzio:

The United States Senate Committee on Finance (Committee) has exclusive jurisdiction over the Medicare program in the Senate. Accordingly, as the Chairman and Ranking Member of the Committee, we have a responsibility to the more than 45 million Americans who receive health care under the program to ensure that program dollars are spent appropriately and to monitor whether safe and appropriate care is provided to beneficiaries. This responsibility includes conducting oversight of services and care provided by institutions that participate in the Medicare program, including long term care hospitals (LTCHs).

We are writing regarding the February 10, 2010, New York Times article entitled "Long-Term Care Hospitals Face Little Scrutiny" in which Select Medical Corporation (Select Medical) is discussed. A copy of the article is enclosed. This article describes a number of disturbing incidents reported to have occurred in Select Medical LTCHs that allegedly resulted in patient deaths and contains a host of other allegations about Select Medical including, but not limited to:

- Unusually high rates of violations of Medicare requirements;
- Poor health care quality;
- Inadequate staffing in terms of the type and number of practitioners;
- High staff turnover rates; and
- Inadequate patient monitoring.

The article also suggests that Select Medical has a corporate culture of putting profits before patients.

We find these allegations to be of great concern, especially if they are systemic in facilities operated by Select Medical or in the LTCH industry as a whole, as the article suggests. If these allegations are true, then Medicare beneficiaries who receive services at LTCHs are being exposed to an unreasonable risk of harm.

Accordingly, in an effort to obtain more information about the issues presented in the New York Times article, we ask that you respond to the following questions and requests for documents by no later than March 22, 2010. In responding, please repeat the question followed by the appropriate response.

1. How many LTCHs does Select Medical own or operate? Please provide a list of the names and locations (city and state) of these LTCHs. Of these LTCHs:

    a. Which LTCHs are freestanding?

    b. Which LTCHs are located in another facility?

2. Does Select Medical have physicians on staff at its LTCHs? If so, please respond to the following:

    a. What is the average number of physicians on staff in a Select Medical LTCH as well as the range?

    b. What percentage of the average number of total staff in a Select Medical LTCH does the average number of physicians represent, and what is the range?

    c. What specialties are represented among physicians on staff?

    d. What percentage of physicians on staff are Select Medical employees and what percentage of physicians are on staff by contractual arrangement?

    e. What is the average number of hours that physicians on staff spend at Select Medical LTCHs, and what is the range?

    f. Do any of your responses to question 2a-2d differ by type of LTCH (freestanding or hospital-within-hospital) or other facility characteristic?

3. Does Select Medical have physicians on staff in its LTCHs on a 24 hour, seven days per week basis?

    If so, please respond to the following:

    a. What percentage of Select Medical LTCHs have physicians on staff on LTCH premises on a 24/7 basis?

    b. Does this percentage differ between freestanding or hospital-within-hospital LTCHs?

    If not, please respond to the following:

    c. What is done to ensure physician coverage on a 24/7 basis? Please provide copies of all corporate policies and protocols concerning 24/7 physician coverage and identify all changes made to these policies and protocols since 2004.

4. The New York Times identified 22 reports from Medicare inspectors citing "condition level" violations at Select Medical LTCHs. Please provide all documents and communications regarding "condition level" violations identified by Medicare at Select Medical LTCHs from 2007 to the present.

5. Provide copies of corporate policies, protocols, and directives regarding the discharge of patients and patient length of stay at Select Medical LTCHs from 2004 to the present. Please also include information on average length of stay and range for patients in Select Medical LTCHs.

6. Are physicians on staff involved in the administration and/or management of Select Medical and/or its individual LTCHs? If so, please respond to the following:

    a. Describe the extent of physician involvement in hospital-level committees that have responsibility for:

        1) Oversight/governance;
        2) Quality assurance;
        3) Quality improvement;
        4) Compliance;
        5) Patient safety; and
        6) Practice standards.

    b. Describe the extent to which physicians are medical directors in Select Medical LTCHs. Please include the following:

        1) The percentage of medical directors that are employees of Select Medical and the percentage that serve as medical directors on a contractual basis;

        2) The average number of hours that medical directors spend at Select Medical LTCHs as well as the range.

    c. Describe the extent to which physicians hold corporate executive/leadership positions at Select Medical, and identify the positions.

    d. Describe the extent to which physicians hold corporate-level positions such as "chief medical officer" or corporate-level positions concerning quality assurance, quality improvement, compliance, patient safety or practice standards.

    e. Describe the extent of physician involvement in corporate-level committees that have responsibility for:

        1) Oversight/governance;
        2) Quality assurance;
        3) Quality improvement;
        4) Compliance;
        5) Patient safety; and
        6) Practice standards.

7. Does Select Medical have corporate-wide policies and protocols to address emergency situations in LTCHs? If so, please respond to the following:

    a. Provide copies of all policies and protocols to address emergency situations in Select Medical LTCHs and also provide previous versions since 2004.

b. Identify what capabilities that Select Medical LTCHs are required to have to address emergency situations including:

    1) Equipment;
    2) Staffing;
    3) Staff training and certifications.

c. Please indicate how long the requirements identified in question 5b have been in effect and identify any changes made since 2004.

d. Please indicate if your responses to questions 5a, 5b or 5c differ by type of LTCH (freestanding or hospital-within-hospital) or other facility characteristic.

8. Does Select Medical have corporate-wide policies and protocols on or related to patient monitoring? If so, please respond to the following:

    a. Provide copies of all policies and protocols on patient monitoring in Select Medical LTCHs and also provide previous versions since 2004.

    b. Identify what capabilities that Select Medical LTCHs are required to have to monitor patients including:
        1) Equipment;
        2) Staffing;
        3) Staff training and certifications.

    c. Please indicate how long the requirements identified in question 6b have been in effect and identify any changes made since 2004.

    d. Please indicate if your responses to questions 6a, 6b or 6c differ by type of LTCH (freestanding or hospital-within-hospital) or other facility characteristic.

9. Does Select Medical have corporate-wide staffing requirements for LTCHs? If so, please respond to the following:

    a. What types of direct care providers are required to staff Select Medical LTCHs?

    b. What is the average number of direct care providers, by category and in total, in Select Medical LTCHs and what are the ranges, by category and in total?
    c. What is the average staff-to-patient ratio in Select Medical LTCHs, by direct care provider category and in total, as well as the range by category and in total? Please also provide a staffing ratio broken down over a 24-hour period.

    d. What is the average staff turnover ratio in Select Medical LTCHs, by direct care provider category and in total, as well as the range by category and in total?

e. Please identify any changes made to Select Medical's corporate-wide staffing requirements for LTCHs since 2004.

10. Please identify each federal and state agency or private accrediting body that has inspected/surveyed Select Medical LTCHs during each year since 2004. For each agency or private accrediting body, please indicate:

    a. The number of inspections/surveys each year;

    b. The outcome of each inspection/survey and the identity of the LTCH inspected/surveyed;

    c. If any deficiencies were discovered, what was the disposition of such findings; and

    d. If any citations/penalties were issued, when, and what follow-up, if any, ensued.

In cooperating with the Committee's review, no documents, records, data or information related to these matters shall be destroyed, modified, removed or otherwise made inaccessible to the Committee.

Thank you for your attention to this important matter.

Sincerely,

Max Baucus
United States Senator
Chairman of the Committee on Finance

Chuck Grassley
United States Senator
Ranking Member of the Committee on Finance

Enclosure

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The New York Times
February 10, 2010

Long-Term Care Hospitals Face Little Scrutiny

By ALEX BERENSON

No one at the hospital noticed that Tina Bell-Jackman was dying.

On the night of June 26, 2007, Ms. Bell-Jackman turned restlessly in her bed in Room 7 at Select Specialty Hospital of Kansas City, a small medical center that specializes in treating chronically ill patients. Ms. Bell-Jackman, a 46-year-old with diabetes, had been hospitalized at Select for five weeks, was increasingly agitated and could not speak because of a surgical hole in her throat. Her physicians had ordered the hospital to keep a sitter with her.

But at 8 p.m., the sitter left, according to a state court lawsuit and a Medicare inspection report. Left alone, Ms. Bell-Jackman tried to get up. Around 9:30 p.m., staff members tied her down with wrist restraints. Around 12:15 a.m., after the restraints had been removed, a nurse injected her with a sedative to calm her.

In other hospitals, an attending physician might have seen Ms. Bell-Jackman. But the Select hospital of Kansas City has no doctors on its staff or its wards overnight. In emergencies, it must call in physicians from outside.

More than 400 similar facilities, called long-term acute care hospitals, have opened nationally in the last 25 years. Few of them have doctors on staff, and most are owned by for-profit companies. The Kansas City hospital is part of a chain called the Select Medical Corporation, a publicly traded Pennsylvania company that runs 89 long-term hospitals, more than any other company.

Lawsuits, state inspection reports and statistics deep in federal reports paint a troubling picture of the care offered at some Select hospitals, and at long-term care hospitals in general.

In 2007 and 2008, Select's hospitals were cited at a rate almost four times that of regular hospitals for serious violations of Medicare rules, according to an analysis by The New York Times. Other long-term care hospitals were cited at a rate about twice that of regular hospitals.

Long-term care hospitals also had a higher incidence of bedsores and infections than regular hospitals in 2006, the most recent year for which federal data is available.

Fewer than 10 hospitals dedicated to long-term care existed in the early 1980s, according to Medicare officials. But many such hospitals have sprouted since then, driven by Medicare rules that offer high payments for hospitals that treat patients for an average of 25 days or more. Long-term care hospitals now treat about 200,000 patients a year, including 130,000

Medicare patients — at a projected cost of $4.8 billion to the government this year, up from $400 million in 1993.

Unlike other specialized hospitals, like psychiatric or children's hospitals, long-term care hospitals do not treat specific types of patients or offer services unavailable in regular hospitals. They are defined solely by the fact that they keep patients longer than other hospitals. They are also smaller than a typical hospital, averaging about 60 beds.

Many patients at hospitals that specialize in long-term care are very sick. While usually in stable condition, they may be on dialysis, need a ventilator or have wounds that will not heal. If patients need surgery or suffer serious medical emergencies, they are usually transferred back to general hospitals.

Nontraditional Hospitals

Despite the rapid expansion of long-term care hospitals and the serious illnesses they treat, Medicare has never closely examined their care. Unlike traditional hospitals, Medicare does not penalize them financially if they fail to submit quality data.

Supporters of long-term hospitals say that even without staff physicians, they provide high-quality care and play an important role by treating patients who are too sick for nursing homes but are not improving at traditional hospitals. Hospital intensive care units help patients survive acute illnesses, heart attacks and trauma, but they are not intended to treat patients for weeks or months.

Of course, traditional hospitals can move those patients to regular medical wards for treatment. But under Medicare payment rules, traditional hospitals often lose money on patients who stay for long periods. So they have a financial incentive to discharge patients to long-term hospitals, which then receive new Medicare payments for admitting the patients. Both hospitals benefit financially.

That dynamic, rather than evidence that long-term hospitals benefit patients, has driven their expansion, said Dr. Jeremy M. Kahn of the University of Pennsylvania, who has received a federal grant to study the hospitals. The industry's growth is an example of how health care companies can exploit the $450 billion Medicare program, he added.

"The U.S. health care system allows unintentional financial incentives to drive sweeping changes," Dr. Kahn said.

The questions about long-term care hospitals center on the for-profit side of the industry, led by Select and Kindred Healthcare, another publicly traded company.

For-profit long-term hospitals generally spend less on patients and have higher margins than comparable nonprofits, according to data from the Medicare Payment Advisory Commission, a Congressional research agency. In 2007, for-profit long-term care hospitals had margins of 6 percent on Medicare patients, while regular hospitals lost an average of 6 percent on Medicare patients, according to the commission.

In a presentation to investors last month, Select Medical reported that it improved its margins by monitoring staffing levels and lowering supply costs.

Medicare inspection reports, however, describe preventable patient injuries and deaths, and they portray Select's hospitals as understaffed and with high turnover.

In the last three years, inspectors have found 22 violations of care standards at 12 Select hospitals so serious that, if uncorrected, could lead Medicare to ban those hospitals from admitting Medicare patients.

The 22 violations represent an estimated 2 percent of the serious violations Medicare found nationally, even though Select operates less than half a percent of the nation's hospital beds. Put another way, on a per-bed basis, Select hospitals were cited about four times as often as the average.

Select also appears to manage how long patients stay, to maximize its profits. A hospital is certified as a long-term care hospital and receives high Medicare reimbursements if most patients stay at least 25 days. But Medicare pays the hospital a set amount for each patient, meaning that patients who stay longer than that become less profitable.

Therefore, long-term care hospitals are most profitable if most patients are discharged at or just after their 25th day, with a few discharged earlier. Select adheres closely to this formula, with an average length of stay at its hospitals of about 24 days, according to public filings. At some Select hospitals, the 25th day is called the "magic day," ex-employees say.

And in 2007, an inspector for Medicare found that a case manager at a Select hospital in Kansas had refused to discharge a patient despite the wishes of his physician and family. The hospital calculated it would lose $3,853.52 if it discharged the patient when the family wanted, the inspector found.

Select strongly defends its care. In a statement, the company said that the Medicare reports represented isolated incidents, that it corrected any problems that inspectors found and that it did not discharge or hold patients for financial reasons.

“In 13 years of operating hospitals, we have a demonstrated record of regulatory compliance and quality patient care,” the company said in a statement. While Select hospitals do not have physicians in-house around the clock, they always have doctors on call, said Carolyn Curnane, a Select spokeswoman. And its patients, like those at other hospitals, are seen by physicians at least once a day.

Select also said that a privately maintained database showed that it was better at weaning patients off ventilators and helping them avoid pneumonia than typical hospitals.

“The picture you draw about Select Medical is inaccurate and misleading,” the company wrote in response to a reporter’s questions about the Medicare findings.

Partly owned by a private equity firm, Select Medical sold shares to the public in September. Its top two executives, a father and son named Rocco and Robert Ortenzio, have made about $200 million from salary, benefits and share sales since founding Select in November 1996. The Ortenzios, who are veterans of the for-profit hospital industry, still own about 10 percent of the company, worth about $200 million.

Hiring a Director

Select, which has 23,000 employees and provided care to 42,000 patients in 2009, has no physicians on its board or in management. In 2007, it hired a physician for a new position, national medical director. The physician, Dr. David Jarvis, does not work at Select’s headquarters in Mechanicsburg, Pa., and has no management responsibilities. He estimated he spent only 10 hours a week working for Select Medical.

“I’m sort of part time,” Dr. Jarvis said. He said that Select Medical “would probably benefit” from having a full-time physician on staff. Select’s corporate medical officer, Mary Burkett, is a registered nurse who is not listed among the company’s top 10 executives on its financial statements.

Select said that it had several corporate-level employees responsible for ensuring safe care and that each hospital had a full-time quality manager. “In addition, a corporate survey nurse makes unannounced hospital visits to look for potential problems,” the company wrote. “Unfortunately, we

cannot prevent our staff, as well trained as they are, from making mistakes on rare occasions."

Select allowed a reporter to tour its hospital in Nashville, where Dr. Jarvis sees patients, though he is not on the hospital's staff. During a four-hour visit in December, the hospital appeared clean and well run. Patients and their families said they were happy with the care they received.

Dr. Jarvis defends Select and the industry, saying that long-term care hospitals play an important role by caring for patients who are not improving at traditional hospitals. Nurses and aides at traditional hospitals may grow frustrated with such patients, but Select's nurses and aides are used to them, he said. And after aggressive intensive care treatment, long-term patients need gentler care that will enable them to recover on their own.

"These people do better when we don't overdo it," he said.

Patients who need scans or more intense care can be transferred back to traditional hospitals. But some patients cannot be saved even with the best care, he said. Indeed, about 12 percent of Select's patients die while hospitalized. "We see such sick people," Dr. Jarvis said.

Among the more peculiar aspects of long-term care hospitals is that nearly half of them, and almost all of Select's, are actually "hospitals within hospitals." They do not have their own buildings and instead occupy a floor or two of an existing hospital. They contract most services from the host hospital, so they can be opened quickly and cheaply.

Yet under Medicare rules, because they have different owners, the two hospitals are considered separate for payment purposes. This means there can be a second reimbursement when a patient is simply transferred between floors.

A Case Is Settled

Select's Kansas City hospital sits on the fourth floor of the Overland Park Regional Medical Center, in a Kansas City suburb. On Oct. 7, 2004, Bill Dean Borum lay in bed there, recuperating from a forklift accident that had led doctors to amputate part of his left leg.

Mr. Borum, 69, also suffered from diabetes and a perforated bowel. Nonetheless, after a month at Select, he had been weaned from a ventilator, according to Wanda Stagg, his sister. "I went to see him almost every single day, and he was starting to talk better and do better," Ms. Stagg said.

Then, around 5 a.m. on Oct. 8, a nurse at Select called Ms. Stagg, telling her that her brother had died of a heart attack. Sheryl Laing, who was the hospital's director of quality, later told Ms. Stagg that a nurse had turned off Mr. Borum's heart monitor because the nurse was tired of listening to the monitor beep.

In October 2005, Ms. Stagg and Mr. Borum's daughter sued. The case, in state court in Kansas, was dropped in 2006, after Select paid Mr. Borum's family $195,000, according to court records. The nurse involved was fired, Ms. Laing said.

Select did not admit liability in the settlement. In answer to questions about the case, Select said that its "monitoring policy in place at that time met the prevailing standard of care" and that the death resulted from "human error and a failure to comply" with the company's policy.

Because of Mr. Borum's death and a second event she described, Ms. Laing pressed Select's corporate officials to let the hospital hire a clerk to watch the heart monitors, she said. Patients' rooms lay on a long corridor, with the nurses' station at one end. "You could be fairly close and not be able to hear the monitors," Ms. Laing said.

But Select Medical refused, saying that nurses should check the monitors, also called telemetry machines, between their other duties, Ms. Laing said. Jason Hedrick, an occupational therapist who was the hospital's chief executive at the time, offered a similar account in a deposition in September 2008. Asked why Select Medical had refused to hire a clerk, Mr. Hedrick said, "I would say that it's, it's a financial reason."

Select said in a statement that it disputed the accounts of Ms. Laing and Mr. Hedrick and that they never asked the company for a clerk.

Ms. Laing joined the Select Kansas City hospital as a nurse in 2002, after years working as a counselor at a center for veterans. She was promoted to director of quality in the summer of 2004. In December 2006, she was promoted again, to director of clinical services. Despite the promotions, she grew frustrated with Select Medical's corporate management. She said she believed that Select's failure to spend adequately put patients at risk.

Alarms Sound

Select had not hired a person to watch the telemetry machine on May 25, 2007, when Tina Bell-Jackman was admitted from Overland Park Regional, the host hospital for Select. Ms. Bell-Jackman, a smoker who suffered from

poorly controlled diabetes, needed a ventilator to breathe. Slowly, she regained her strength.

By late June, she could breathe unaided and walk a few steps, though she was unable to speak because surgeons had cut a hole in her throat for a tracheostomy tube. “She was getting ready to leave the hospital,” Ms. Laing said. “She was never going to be a really healthy person, but it seemed like she was on the way to being her best.”

After the sedative injection at 12:15 a.m. on June 27, Ms. Bell-Jackman seemed to relax. But at 12:42 a.m., the leads connecting her heart monitor to her chest came loose. The machine sounded an alarm at a nursing station. No one responded.

As her alarm rang and the minutes ticked by, Ms. Bell-Jackman went unaided. Finally, during a bed check at 2 a.m., Samuel A. Danso, the nurse responsible for treating Ms. Bell-Jackman overnight, noticed she was unconscious. Efforts to revive her failed. She was pronounced dead the next day, without having regained consciousness.

Two days after Ms. Bell-Jackman’s death, the hospital fired Mr. Danso. He did not return calls for comment.

In a scathing report after Ms. Bell-Jackman’s death, Medicare inspectors found that the hospital did not have enough nurses on the night she died and that the volume on her monitor was turned down. “The audible alarms could barely be heard,” inspectors wrote. In addition, although staff members “recognized the need to report the death” because she had been in restraints, “they stated the corporate legal department advised the hospital not to report the death” to Medicare.

Select’s lawyers did not think that the company needed to report the death, the company said.

On July 18, a week after the Medicare inspection, Select Specialty hired a full-time technician to watch the heart monitors. In September 2007, Select fired Ms. Laing. The company did not give a reason for her firing, she said. But she says she believes it had grown tired of her complaints about its practices. Select declined to comment about Ms. Laing’s dismissal.

In January 2008, Ms. Bell-Jackman’s family filed suit against the hospital in Johnson County Court in Kansas, later adding Select Medical, the parent company, as a defendant. In June 2009, the hospital, which is insured separately from the parent company, settled the claim against it by paying Ms. Bell-Jackman’s family $800,000, while denying wrongdoing. On Jan.

20, after being asked by The New York Times about the case, Select Medical agreed to a settlement with Ms. Bell-Jackman's family. Terms were not disclosed.

Through their lawyer, Dr. Samuel K. Cullan, the family declined to comment.

In a statement, the company said: "Ms. Bell-Jackman's death was a tragedy for which we are deeply sorry. Select conducted an appropriate clinical review following Ms. Bell-Jackman's death and terminated a clinician involved in her care." As for Ms. Laing, she now works at a veterans' hospital in Leavenworth, Kan., where she says she is much happier. She added that she regretted not reporting her concerns to state inspectors or Medicare officials.

"I should have been more verbal with outside entities, but sometimes you get in a situation where that's not your first thought," she said. "You just try to do the best you can with what you have."

"Just talking about this makes me mad, because it shouldn't have happened this way," she said. "She shouldn't have died in our hospital."

Many other Select hospitals have problems, according to Medicare inspectors. But questions about patient safety at long-term care hospitals extend well beyond Select's hospitals.

In 2006, nine out of 1,000 Medicare patients developed serious infections in long-term care hospitals, according to a March 2009 report from the Medicare Payment Advisory Commission. In contrast, fewer than three out of 1,000 patients over 65 — a group made up almost exclusively of Medicare patients — developed infections at traditional hospitals that year, according to the federal Agency for Healthcare Research and Quality.

But Medicare has few levers to discipline long-term care hospitals, or any hospitals. Hospitals must submit plans to correct the problems that inspectors find, but the program cannot impose fines or reduce payments. In theory, Medicare can force hospitals out of the program, but because that penalty is like forcing a hospital to close, the agency almost never uses it.

"It is typically only when the deficiencies are chronic or serious, such as when they directly affect patient care, that Medicare will take the unusual step of threatening decertification," said Robert L. Roth, who was a senior lawyer for Medicare.

In 2009, when Medicare tried to force out the Select hospital in St. Louis, the company sued. A federal judge found the penalty unwarranted and granted an injunction forbidding Medicare to follow through. The violations in the St. Louis case did not directly harm patients, the judge found. The two sides eventually settled, with the hospital agreeing to hire outside experts.

For years, Medicare reimbursement rules have encouraged the growth of long-term care hospitals, said Dr. Christopher E. Cox, an associate professor of critical care medicine at Duke University.

Under Medicare, hospitals receive a payment for a patient based on the patient's diagnosis, not the cost of care. Patients who recover quickly are profitable, but those who languish are not. "A lot of the time, hospitals would be losing money on these kinds of patients," Dr. Cox said.

But if a regular hospital transfers a patient to a long-term care hospital, the long-term hospital gets a payment from Medicare that averages about $40,000. Meanwhile, the regular hospital frees up a bed for a new patient — and new reimbursement.

Because long-term care hospitals do not have emergency rooms, they choose which patients to admit. Medicare tries to prevent them from admitting patients who could be treated less expensively at nursing homes, but its rules are applied loosely, if at all, said Dr. Kahn of the University of Pennsylvania. "They can pick the most profitable types of patients," Dr. Kahn said.

Moratorium

During the 1990s, as medical entrepreneurs like the Ortenzios recognized that long-term care hospitals were relatively cheap to set up and could be run profitably, companies rushed to open them. Spending on such hospitals soared to $4.5 billion in 2006, from $1.9 billion in 2001 and $398 million in 1993.

Concerned about costs, Medicare began tinkering with its rules to slow the industry's growth. The agency limited the number of patients that hospitals-within-hospitals could admit from their hosts. It said that if patients were admitted to a long-term care hospital and then rapidly returned to a regular hospital, it would not pay multiple reimbursements.

Nonetheless, the industry continued to grow. Finally, in December 2007, Medicare instituted a three-year moratorium on new long-term care hospitals. The freeze has slowed, but not stopped, the industry's growth.

After soaring for more than a decade, Medicare spending on long-term care hospitals has been flat the last two years.
But the moratorium expires in December of this year. And even if it is extended, existing long-term hospitals will continue to admit nearly 200,000 Medicare, Medicaid and private insurance patients a year, without any proof that they match the quality of traditional hospitals, Dr. Kahn said. Despite the moratorium, he said, Medicare has never “taken steps to curb the perverse financial incentives” that drove the long-term hospital explosion.